The health crisis in the United States is not just a matter of organization, or financing, or the participation of unrepresented consumers. It is all of these, but equally critical is the problem of health policy and the role of the health professional in shaping it. This provocative analysis calls attention to this important aspect of our current situation and suggests ways of dealing with the problem.

THE UNSOLVED PROBLEM OF THE CAREER PROFESSIONAL IN THE ESTABLISHMENT OF NATIONAL HEALTH POLICY

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THIS nation is facing a serious problem in the development and implementation of broad national policies for the organization and administration of the delivery of health services, for medical and health education and research. There is a need for a coordinated stable means whereby such policies can be formulated, legislated, and activated. This need has been recognized and efforts have been made to bring order out of confusion. However, the plethora of health legislation recently passed without adequate coordination has accentuated our problems. This country is now almost overwhelmed by crises resulting from increasing health costs, by demands for incentives and control of quality and cost in the newly legislated programs, by inadequate health manpower, by obsolescence of facilities, and by tensions resulting from the battle between those attempting to maintain the status quo and those wishing to change.

Government (local, state and federal) is increasingly assuming a complicated role in our national health program through multiplying and expanding agencies and bureaus, and through the assumption of a greater percentage of the costs of health care. The public is demanding a greater voice in the setting of policy and in the delivery of health care. Critics of the existing system of health care in this country refer with considerable justification to our "non-system" which they say is in need of a drastic, evolutionary—if not revolutionary—revision.

Our difficulties in meeting these challenges are not those of identifying problems or of projecting idealized objectives. These we have in great profusion whenever sensitive, perceptive, or critical individuals gather to discuss the local or national health scene. Rather, our problems are to find the proper solutions through the mechanism of assignment of responsibility for obtaining accurate facts and of developing alternatives, in developing an efficient organization or medium by which the decision-making process may be carried out, and in selection, training, and retention of individuals who are competent to assume responsibility for planning, decision making, and implementation.

Logically, the federal government should be able to depend for advice, if not solution, upon the health component

of the Department of Health, Education, and Welfare, particularly the Public Health Service. However, the growth of the magnitude of the national health needs, concomitant with the repeated and continuing reorganization, has resulted in uncertainty and confusion on the part of the governmental career staff as to its responsibility, its authority, or its future. This has substantially impaired orderly or coordinated planning of health programs.

At least two broad areas of health policy associated with these present problems can be identified that are of concern to the public and that deserve possible exploration and discussion. The first is the responsibility of the Department of HEW and its PHS for the development of national policy for health and for the administrative organization for planning and implementation of the national health care programs. The second is the recruitment, education, training, and retention of competent, qualified, career professionals in health administration who are provided an attractive and stable environment in which they are able to function effectively. These areas are interrelated for, as the federal government plays an increasing role in the financing and in the determination of policy for health care in this country, the career professional in health administration, both in and out of government, will determine in substantial measure (directly or through advice to political or community bodies) the nature of our health system.

The Department of Health, Education, and Welfare and the Public Health Service

The major change that has taken place in HEW has been in the responsibility and authority of the PHS, its Surgeon General and its Commissioned Corps, so that this agency is currently unable to assume the leadership roles or responsibility for national health affairs that it has had in the past. This change has been developing for a number of years. It has recently been accentuated by a series of administrative reorganizations and political realignments that has attracted little public attention or understanding, but has been revolutionary in its effect upon a once major force in health policy in this country. It is difficult to identify the forces and circumstances—or even the reasons—that caused this change. It is important, however, to understand its evolution if constructive planning is to be undertaken to build upon the past, so as to supply the leadership for the future.

From its inception, in 1798, the PHS has provided the facilities and the leadership for meeting health problems in this country in areas or in situations where there were otherwise inadequate or absent resources. Its care of the merchant seamen, its concern with quarantine and communicable diseases, its efforts in sanitation and in environmental health, and its pioneering work in bacteriology, virology, parasitology, nutritional diseases, and the handling of epidemics—all reflected problems and challenges in community health requirements in which the PHS had the expertise and was the prime source and repository of knowledge.

In more recent decades, the PHS, through its National Institutes of Health and the Clinical Center at Bethesda, has played a similar role in basic and clinical research. The early standards for hospital construction and for regionalization through the Hill-Burton Program are examples of contributions made through the expertise of the PHS. Another major contribution of the PHS has been the development of individuals who could assume responsible administrative posts within the federal system, throughout state and area public health agencies, and also in the private sector of health and medical education. The

number of PHS staff who have moved into important private sector posts in health administration is legion.

The scope and variety of health matters requiring national attention have burgeoned almost geometrically since the Reorganization Plan No. 1 of 1953[1] created a Department of Health, Education, and Welfare. The growth has been particularly evident since 1960. This occurred without a concomitant increase in the numbers of professional staff, particularly in those few career members of the Commissioned Corps who had the appropriate education, experience, or motivation to assume these new health care responsibilities. The traditional "nurseries" of PHS health administrators (the PHS hospitals and the newer Indian Health Services) were increasingly limited by budgetary means from providing additional trained health personnel. Salary scales also became increasingly noncompetitive.

Moreover, the federal government, through the PHS and its NIH, created and financed competing "islands of excellence" in the universities and in the medical schools in those very scientific and clinical fields that heretofore had been the primary responsibility of the PHS. Thus an expertise outside the PHS was developed and, ironically through the support of NIH, these outside "islands of excellence" now competed with the PHS for trained personnel who were in short supply.

Over the past 20 years, medical care, the delivery of medical services, and a markedly increased social responsibility for health care became important issues to the public, to Congress, and to health leaders in general. Although a number of individuals of the Commissioned Corps did provide significant leadership in these new issues, neither the PHS nor its career officers in general appeared to give the whole-hearted commitment that public representatives expected. Part of their presumed deficiencies may well have been due to the unwillingness or the inability of the traditional Public Health Service career administrator to be interested or competent in the field of medical service or medical care. In this regard, the national PHS individual probably differed little from his local or state public health counterpart —his expertise and orientation were not directed toward medical service, and his attitude was conditioned by the assumption that patient-care was the prerogative of private practice.

Part of this hesitancy was undoubtedly due to the position taken by the American Medical Association and its organized medicine components at the county and state levels in opposition to any activity by public health officers related to the provision of medical care as contrasted to such traditional public health interests as sanitation, infectious disease, or research. PHS staff members who were interested or who tried to take any substantial leadership role in medical care as a part of public health were possibly endangering their professional futures.

As a result, the leadership and the initiative for social medicine and for the greater involvement of the government in health care came from the "new boys" who were neither PHS career administrators nor Commissioned Corps, but were rather "medical care-niks" from various universities, social welfare staff of labor unions, and social scientists completely independent of the PHS. Leadership also came from politicians, who recognized a growing public demand and the attractive political posture that might result from a greater concern in the provision of medical care.

By the early 1960's, there appeared to be substantial disenchantment and dissatisfaction on the part of the Administration toward the Commissioned Corps of the PHS. It was considered by many to be unwilling or unable to meet

modern problems related to the administration and the delivery of health services. There was serious criticism of the "somnolence" of the PHS and of the Commissioned Corps. Some of these criticisms involved the apparent inability to adapt to the new demands of altered government responsibility, the organizational rigidity along military patterns, and the failure to exercise leadership in—or even to anticipate—emerging problems.

The status of the Commissioned Corps was not helped during the long battle over Medicare when it was believed that many members of the corps remained aloof until the new program was about to be passed. This is not entirely correct, for the record shows active participation by a number of PHS staff during the developmental phases of Medicare. However, the PHS officially was certainly not in the forefront as a Medicare Program advocate. The Commissioned Corps also faced the problem presented by a growing number of other federal civil servants in health programs outside of the PHS. They actively resented the relatively small "elite" group that appeared to favor the doctor or the individual who had come up through the traditional PHS Commissioned Corps ranks. They considered that a military-type structure, dominated by physicians, interfered with the recruitment and promotion of other professionals and had a stultifying effect on the service.

Finally, there was also the philosophical, political, and practical question as to the propriety of having the power over the distribution of literally billions of dollars for health in the hands of an elite Commissioned Corps, theoretically answerable to the secretary and to Congress but actually making many of the decisions itself.

As the number of dollars, people, and programs increased over the past few years, the existing organization of the PHS, with its limited number of career personnel and its traditional orientation, was overwhelmed and was bypassed. Health programs were developed at the federal level outside of HEW, such as Head Start and Neighborhood Health Centers, under the Office of Economic Opportunity, and Model Cities, under Housing and Urban Development.

All of these required large amounts of dollars and of personnel, and all were independent and were essentially competing with HEW and PHS. Within HEW, but outside of PHS, was the development of other major health programs, such as Medicare under the Social Security Administration; Medicaid, under the Social and Rehabilitation Services; the Maternal and Child Health Programs, administered by the Children's Bureau; the Regional Medical Programs; Comprehensive Health Planning; and Mental Health and Mental Retardation Planning. Career officers were assigned to direct or to function in a liaison fashion in many of the new government programs but their numbers were few, and subsequent administrative reorganizations encouraged resignations and discouraged enlistment.

Over the past decades, the PHS also developed a rapidly expanding program of extramural and intramural education and research emanating from its National Institutes of Health. As the NIH and its popularity and funding grew, there occurred an increasing competition and gulf between the NIH on one hand and the Surgeon General and the rest of the PHS staff on the other to the extent that one of the major components of the PHS became essentially independent of the Surgeon General and the remainder of the PHS.

The net result of the last decade of growth and the magnitude and complexity of federal health programs, of the seemingly geometrical increase in federal funds committed to health, and of the competition for manpower, for

funds, and for authority, has been a veritable epidemic of reorganization of HEW and of the PHS that presently appears to be endemic.

The last cycle of formal planning for the reorganization of the PHS started within the service around 1959-1960.[2] This was stimulated by the late Representative Fogarty, who recognized the need for a concern about "environmental health." At that time, the leaders of the PHS assumed the responsibility for conducting a service-wide study that would serve as a basis for a reorganization of the PHS from top to bottom. It is of importance to note that, in this 1960 study, recognition was given to the need for greater emphasis on the provision of health services to people, as contrasted to the major effort previously given to research and health education. Stress was placed upon the increased support to the training of doctors and nurses, on greater support for hospitals, diagnostic centers, and nursing homes, and on more activity in environmental health and in areawide health planning.

In fairness to the record, it should be emphasized that this 1960 report and its philosophy came from a committee and a staff made up of leaders of the PHS who were largely from the Commissioned Corps—the very group that has been accused by many of being reactionary, conservative, or nonperceptive.

The 1960 report resulted in a number of administrative and organizational changes in the PHS, but did not recommend substantive changes in the office of the Surgeon General. It was followed by a series of National Commission Reports upon Health, Manpower, Hospital Effectiveness, Health Facilities, Vocational Rehabilitation, and Group Practice. These studies provided excellent documentation of need in a known particular field, but primarily resulted in outlining desired goals. There resulted only a minimum of implementation.

Following the 1960 report and the publication of the various commission studies, dissatisfaction still existed within the Administration over the ability of the PHS to carry on its responsibilities. Because of the great growth of activity in the federal health establishment after 1960, the then secretary of HEW, John Gardner, commissioned the 1966 reorganization under the direction of John J. Corson, Ph.D., and a committee drawn from outside the department. The result was a substantive change (Reorganization Plan No. 3 of 1966[3]) that transferred the powers of the Surgeon General of the PHS to the secretary of HEW and also gave the secretary the power to further reorganize the service at any time. This would appear to be one of the major milestones in changing the philosophy or structure of the PHS. It was no longer an organization built around a professional staff, headed by a professional career individual with relative statutory invulnerability, but was now an organization much more subject to changing personalities and to partisan political influence.

In addition to the 1966 reorganization, which caused a reshuffling of the bureaus and services within the PHS, there was also a substantial weakening of the authority of the Office of the Surgeon General and an erosion of staff support. The Surgeon General was not given line control over programs, budget, or staff for planning. His position appeared to evolve into a staff adviser to the Assistant Secretary for Health and Scientific Affairs—a newly created political position. The Surgeon General also physically moved his office from the main administrative building of HEW to Bethesda—presumably to assume greater authority over the domain of NIH with its atmosphere of research as contrasted to service. This was not a successful venture. Later, after new personnel and organizational alignments had been established in the secretary's

office in Washington, the Surgeon General moved back to the central administrative building of HEW but into a completely changed environment.

Before the 1966 reorganization was even officially in effect, Secretary Gardner announced his intention for further changes of the PHS. The new plan, which went into effect between March and April, 1968, under the direction of Acting Secretary Cohen, was the product of a second Corson Committee. This created three administrations: research and education (NIH); health services (Health Services and Mental Health Administration); and consumer and environmental health activities (Consumer Protection and Environmental Health Service). All reported directly to the Assistant Secretary for Health and Scientific Affairs, Dr. Lee, who had direct line responsibility for the health programs of the Department of HEW.[4]

Further recommendations were made by Secretary Cohen in June, 1968.[5] One was that a position of Deputy Secretary for Health be approved by Congress. Although congressional approval has not been received for this new position, the realities are that the Assistant Secretary for Health and Scientific Affairs is the administrative officer directly responsible to the secretary for the health programs that are within the purview of the PHS. Thus, the Surgeon General became even more of a staff officer with virtually no supporting staff and no direct operating authority.

The January 20, 1969 article of the "Congressional Quarterly"[6] reports that "Several roles were considered for the Surgeon General, including direct responsibility for operating programs and a purely advisory role. Gardner felt that policy decisions should be made by a politically responsive person (a political appointee), but that a professional who could provide continuity should be in charge of operations. Other top officials agreed with the view. The result was that Stewart was made Lee's deputy with the understanding that he would be responsible for the day-to-day operation of the PHS. Lee was given the responsibility for policy decisions. Such a division of top responsibility was a new experiment in governmental organization."

This would appear sound if the responsibilities and authority were clearly spelled out and if sufficient staff and budget were available. However, it is difficult to understand how the Surgeon General could have been expected to carry out his responsibilties for day-to-day operation with any expertise and authority in the absence of any staff for program planning and evaluation, for budget, personnel, legislative, or administrative affairs. Yet this appears to have been the trend for a number of years, with neither Congress nor the Bureau of the Budget being sympathetic to fund support of the Office of the Surgeon General. This reached its ultimate zenith or nadir (dependent upon one's point of view) when the three administrations and their departmental chiefs, created in 1968 by Secretary Cohen, received much of the Surgeon General's headquarters staff and operating funds.

NIH was particularly fortunate in this regard, inasmuch as past budgeting for major divisions had customarily included a percentage of the overhead for support of the central administrative office. Such a procedure has not been followed for either the Surgeon General or for the Assistant Secretary for Health and Scientific Affairs so that, as programs have expanded, what remaining central administrative staff they had has declined proportionately.

Whatever were the assumptions or expectations of the 1968 reorganization concerning the role and responsibility of the head of the PHS—the Surgeon General—his present position has now become most equivocal. Philip Lee's paper to the National Academy of Engineering,

October 30, 1968,[7] indicates that the Assistant Secretary for Health and Scientific Affairs was given clear line authority for program direction over the three primary health agencies and was also the secretary's alter-ego for Health and Scientific Affairs, rather than a staff adviser.

This has resulted in the political appointee becoming the operational head of the program. With a longevity that so far has not averaged much more than two years, there is little continuity either in policy formation or in program operation. This presents serious problems in a health program so large and complex as exists in this nation—no matter how good the individual may be or how healthy may be his political environment.

Accompanying the reorganization of the PHS was a suggested alteration in the Commissioned Corps. In 1966 consideration was given to a major change in the personnel system of HEW for those engaged in professional public health activities. Legislation was planned to establish a health service personnel system in place of the existing Commissioned Corps.

The purpose of the proposed legislation was noted in one of the drafts of legislation as follows:

"Section II, the Congress hereby finds and declares that at a time when the health expectations of the nation are greater than ever before and when advances in medical technology bring them closer to fulfillment, it is essential that the Department of Health, Education, and Welfare meet its obligations in the health field by requiring the highest standards of excellence of its personnel in the many health disciplines. In order to achieve this, a new health personnel system is needed which can: (1) attract and retain the variety of skilled personnel needed for staffing the health programs of the department as well as those health activities of other agencies served by the department; (2) enable the department to attract and develop personnel uniquely prepared for specialized assignments; (3) take full advantage of the variety of opportunities for long and short term careers in health programs of the government; (4) permit the best utilization of skilled personnel, and the development of these individuals by successive assignments where needed; (5) provide training to develop and update requisite professional skills."

The objectives cannot be criticized. There are those in the Commissioned Corps who consider this preamble as a description of the existing PHS Commissioned Corps. The problems would be in the details of the future program, its implementation and in the transition stages.

The bill, HR 15760,[8] introduced in the House of Representatives by Mr. Staggers on March 5, 1968, was not acted upon by Congress. It was strongly opposed by the Commissioned Corps and was not vigorously pushed by the administration because of conflicting amendments proposed by other bureaus. With the advent of the Nixon Administration, the appointment of a new secretary for HEW, the departure of Dr. Philip Lee from his post as Assistant Secretary for Health and Scientific Affairs, the prolonged battle over the appointment of Dr. Lee's successor, and the planned departure of the Surgeon General, the fate of this legislation changing the Commissioned Corps to a new Health Service Personnel Corps is uncertain.

There is little question, however, but that the several reorganizations of the Public Health Service, the altered status, role, and authority of the Surgeon General, and the continued threat to the Commissioned Corps have all created confusion, uncertainty, and an accentuation in the decrease in morale on the part of the PHS staff. A considerable number of experienced senior members of the professional Commissioned Corps of the PHS have left or are leaving. The remainder are confused and uncertain as to their own future as well as that of the Commissioned Corps. Recruitment is also impaired.

Those who carried through the reorganization of the PHS undoubtedly had as their objectives a stronger, more cohesive, efficient, and responsive organization of HEW and PHS—one that would meet the modern challenges of the health needs of this country. It would appear clear that they felt the liabilities of the existing corps structure were so substantial that a major reorganization was considered necessary to bypass obstructions. However, it is difficult to understand why it was considered appropriate to start on a course that might well destroy the Commissioned Corps—through discouragement, uncertainty and impaired recruitment—without having developed a viable substitute to preserve its intangible and tangible assets.

It is probably engaging in semantics to debate whether the PHS has not already been destroyed. It still exists with a Surgeon General and with a Commissioned Corps. The late Jack Masur described it in a polite veterinarian term as having been "altered." The Commissioned Corps considers that it is fighting for its life—and it is. Ironically, some of its severest critics are among those who were responsible for Medicaid which currently is the cause of critical review of our health policies, our health financing, and our health leadership.

In its original protest, the corps appeared to have placed much of its emphasis upon salaries, perquisites, and retirement policies instead of on basic issues of goals and objectives, responsibilities and future activities. A subsequent position paper in 1969[9] presented sound management and personnel principles that are constructive and do not appear defensive. The position paper has re-emphasized the basic and revolutionary changes in the administrative and organizational structure of HEW and the PHS that have occurred in the recent reorganization. It points out the destruction or the abolition of the career professional and scientific system under professional leadership, and its replacement by a political system of appointees responsible for both policy and management. It also cites the impossible position of the Surgeon General who is assumed to have over-all program management and to be an adviser in policy, and yet apparently only has authority over his immediate associates, with no other staff directly responsible to him. A major weakness of the position paper is that its source is a group or an organization that can be considered prejudiced, defensive, or special pleaders.

There also appears to be undue reliance upon the conclusions of the 1962 Report of the Advisory Committee on Public Health Service Personnel Systems[13] which recommended the continuance of the existing combination of personnel systems if those systems were "used imaginatively and in concert, so that their potentials are fully realized."

The Career Professional in Health Administration

The current problems faced in the federal government in its series of reorganizations, the uncertainty and erosion of the Commissioned Corps, and the impairment of effective functioning of the Surgeon General through the substitution of politically oriented leadership, are only part of the major crisis affecting this nation in the procurement and training of qualified career professionals in health administration. Governmental and private committees, commissions and departments involved in various aspects of health activities have exhaustively discussed the need for adequate numbers of health personnel. Professional organizations have striven to gain higher professional status, better standards, and increased income and perquisites, each for members of its own particular specialty. There has been academic recognition of the professional in

health administration through the development of courses in hospital, medical, and public health administration in many universities at the baccalaureate, master's, and Ph.D. level.

Despite all this emphasis upon health manpower, there has not appeared to be a concomitant clear understanding or acceptance at the national level that trained and experienced leaders are needed in the field of health administration, and that they require an attractive and stable environment if they are to function effectively. Moreover, there has not been any discernible major effort to develop coordinated programs (both public and private) for the procurement and retention of trained and experienced individuals whose responsibility would be to plan and to direct the many facets of health services, the provision of which has become one of the major industries of our nation.

Ideally, an administrator should be an individual with proper training, experience, and temperament to work with and through people. He must understand problems of precedent, organization, personnel administration, and decision making and be able to function with such judicial evaluation that his judgment will be equitable and acceptable, even though the results are in disagreement with the desires of many pressure groups. In addition, the administrator must be able to appreciate the finite quality of money and the selection of activation priorities within dollar limits in terms of potential results. He must balance long-range planning with decisive implementation of programs to meet immediate needs. The success of any operational program depends upon such energetic implementation. It is so easy to delay until there are *more* facts, *more* committee meetings, and *more* planning and philosophizing.

The current needs for administrative manpower are multiplying astronomically. One can list such areas as hospitals, medical schools, universities (vice president for medical affairs), group practice, and other medical organizations; insurance and prepayment programs; the many existing health programs in local, state, and federal governmental departments; newly established governmental programs that in themselves will require an unknown increase of administrators, such as the Regional Medical Programs and the Comprehensive Health Programs, plus an infinite variety of other hospital, community, and planning organizations. In addition, there are the growing complexities of university teaching hospital-medical school departments in which the departmental chairmen themselves are becoming dependent on trained administrative assistants.

As the federal government plays an increasing role in the financing and determination of policy for health care, the career professionals in health administration and the organization and environment in which they work will determine in substantial measure (either directly or through advice to political bodies) the nature of the health care system of this country. This involves assembling and interpreting data, preparing factual and defensible recommendations, and seeing that the programs are properly implemented and evaluated. It requires the involvement of individuals who have the stature, the administrative ability, the experience, the security —and the courage—to stand up to political forces, the public, and special pleaders from industry, hospitals, academia, and organized medicine and "say it as it is," so that wise decisions can be made. The criticism of poor management, made by Representative Fountain and others, can best be answered by having competent and responsible administrators. While many of these responsibilities have been carried out by the Public Health Service and its Com-

missioned Corps in the past, they are less able to do so now and there is no obvious replacement. Despite the imaginative concepts of "creative federalism," "partnership in health," and "public-private partnership," an over-all program to develop career professionals in health administration has not been evident.

Comment

It is not clear just who is taking the initiative in facing the problem of the development of leadership in health matters, or in exploring and deciding upon the fundamental issues that affect the very existence of the PHS and its reason for being. These would include such subjects as its mission, its objectives, and its programs and particularly the responsibility and the authority of the Surgeon General and other federal career professionals in health administration as contrasted to dependence upon management and operation by changing political appointees. The change in status of the Surgeon General of PHS, his loss of supporting staff and of line authority, previously his, over certain bureaus and divisions and the substitution of a political appointee to bear these responsibilities have resulted in a major revolution. There is a consequent vacuum in health leadership in the federal government that is almost unbelievable. The previous Assistant Secretary for Health and Scientific Affairs left shortly after the first of the year, and no new assistant secretary was appointed until late June. The Surgeon General leaves in August along with his chief deputy.

Health problems and programs occupy as much attention in the public press as does Vietnam or welfare, but the professional leadership for health in the federal government has had to depend upon a political appointment that dragged on for some six months. How can one seriously search for the most appropriate successor to the Surgeon General when the job description or even the very existence of the position is open to question? How can so important a decision be reached without discussion, unless by divination? If there still existed a strong, nonpartisan PHS or its equivalent, with a nucleus of career professionals in health administration to give continuity, this political hiatus might be satisfactorily bridged. Unfortunately, this bulwark has been seriously eroded over the years and accentuated more recently. What can be anticipated in the future?

A $55-$60 billion annual expenditure in a field that is as complex, specialized, and personal as that of health requires as highly refined an organization and as well-trained a group of leaders as can be found in any other segment of our society. If the problems of mounting costs for health care and of inefficient systems of delivery of health are to be solved, it will depend upon sound plans developed and implemented by experienced leaders. The development of a universal health insurance system that may be used to give leverage in changing the existing system, such as is advocated by Walter Reuther and the Committee of 100,[10] will only compound our health problems; this holds especially true if adequate programs and staff are not available to help plan such changes and to establish the framework for implementation.

Similarly, it is also unrealistic to expect that more "participatory democracy" will help solve problems when the present health system is handicapped by a lack of leadership, by a multiplicity of directives, and by a plethora of committees and advisory boards. "Participatory democracy" can and should contribute a more meaningful voice for the consumer. However, unless there is adequate organization and trained, experienced leadership, vigorous committees will be substituted for pro forma passive committees—but the same lack of prog-

ress will result, only with more commotion.

All segments of our society share responsibility for the current situation. There is a general misunderstanding of the need, the responsibility, or the authority of the administrator. There are too many who believe that administrative ability is automatically assumed by the conferring of an M.D. degree, by having competence in a medical specialty or in academia, or by being appointed a department chairman, a president, a dean, or a director for planning. Too frequently the administrator has been considered to be a part of the "establishment" and so, by definition, to be against the practitioner, the worker, or the consumer—or even the university students or faculty.

The field of health administration has additionally suffered from the fact that it has been difficult for its graduates to acquire peer status or recognition of the particular specialty of hospital and health administration in contrast to the many other professional specialties (both medical and nonmedical) that somehow have acquired greater respectability. The long efforts to get the American Board of Preventive Medicine to accept this discipline as a distinct medical specialty subdivision for physicians who are concerned with medical care, hospital or community health administration, have been an exercise in futility.

The American Medical Association has only relatively recently started to list administration as an activity or a special interest of physicians, but not yet as a specialty. The American College of Hospital Administrators has made valiant efforts to upgrade the position of the hospital administrator, but the individual who does not possess some additional academic or social attribute has a major handicap to status acceptance.

The great majority of the voluntary hospitals still maintain the fiction that the elected president of the governing board is the chief executive officer of the institution and that the administrator is just a hired hand—an organizational anomaly that dates back to the Lord and Lady Bountiful era of calves' foot jelly and philanthropy, with the matron, the bookkeeper, or the plant superintendent carrying out the dictates of the board. The businessman trustee would not tolerate such an arrangement in his own business. There are still relatively few hospitals or health care organizations that have accepted the precepts of industry and have made the professional career health administrator the true chief executive officer with the authority necessary and commensurate to his responsibility.

The position of the great national voluntary health organizations during the period of reorganization in HEW and the PHS has been rather disappointing. It should have been clear during the past few years that the reorganization of the health care programs of HEW and the altered status of the PHS and the Surgeon General presented possibilities of profound changes that could well affect the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, the American Public Health Association, the American Nurses' Association, the American Dental Association, and the State and Territorial Health Officers' Organization. All these organizations have greatly profited by their association with the PHS and its career professionals in the past. The PHS has served by establishing standards, providing funds, lending personnel and support to voluntary programs for hospital and medical care, for medical education and research, and for public health in states and local areas. Yet there has seemed to be little understanding or reaction by these organizations as to what was happening in the reorganization of HEW and PHS and in the sub-

stantive shift from professional to political control of programs, personnel, and dollars.

One exception has been the continuing effort by the American Public Health Association to re-establish a position of strong leadership for the Surgeon General. Few of the other organizations have reacted to the problems of the future of the PHS or of the Commissioned Corps or with possible successors with even a small fraction of the effort that they have expended trying to preserve the usual, customary fee scale for physicians, the 2 per cent additive to the Medicare hospital reimbursement rate, or the appointment of the Assistant Secretary for Health and Scientific Affairs. Do physicians, hospitals, medical schools and universities want career professionals (trained civil servants) or politically oriented appointees to deal with them in the expenditure of some $60 billion for health? Obviously, this is an oversimplification, but the challenge can very properly be presented to these national voluntary health organizations as to their position on the future of the PHS or its equivalent.

The federal government is particularly derelict in its support of the professional health administrator. It is assuming a greater and greater fiscal and programmatic responsibility for health care and is creating many positions for health care activities, but it has evinced little evidence of attention to the fundamental need of attracting, training, and retaining competent experienced professionals in health care administrration, or in providing an environment or an organization by which continuity and experience can be nurtured.

HEW has a budget second only to that of the Department of Defense in the United States government. The proportion for health is high. The direct and indirect influence of the directives and programs coming from HEW on national and local health matters are beyond any simple analysis. One thing would appear certain: the often repeated preamble in all of the recent health legislation that it should not affect the existing practices of medicine is unrealistic —for changes are occurring at a revolutionary, not an evolutionary, rate and the status quo cannot be so guaranteed. There is thus an increasing need for a stable organization for the development of clear and identifiable missions, goals, or objectives by experienced and trained individuals who have continuity, responsibility, and authority.

The PHS and the Department of HEW have undergone major changes in function and in orientation in the past six to eight years. These changes, which were recognized and anticipated to a considerable extent in the inservice 1959-1960 planning for reorganization, emphasized the provision, quality, and availability of health services and of health personnel, and of proper planning for total health care. Efforts to meet these changed functions and goals of HEW and the PHS are reflected in the present changes in structure and staffing. It would be unrealistic and regressive to defend or to desire the preservation of the establishment of the past just because it was familiar or comfortable. Similarly, it is unrealistic to defend change just because it is change. The issue is not the preservation of the PHS or its Commissioned Corps. These organizations and bodies may well be anachronistic in their present form. The issue is not who should run what or with what authority. The issue is that the nation as a whole and its great national health organizations have a vital stake in the organization, the authority, the responsibility, and the types of personnel who are in leadership positions in the determination of the future health policies for service, education, and research in this country.

There has been neither public understanding nor discussion by concerned parties in the determination of whether there should be a professional-oriented

federal agency for health or health sciences or a political management or technician-oriented organization. Similar questions have not been clearly explored concerning the future of the PHS, how health policies affecting this country should be developed, and how the leaders should be trained and selected to operate this vital industry that affects every man, woman, and child in the United States. Furthermore, there has not been a satisfactory plan or program advanced for meeting our future leadership needs at a time when the existing organization and personnel are confused, demoralized, and disintegrating and the very position of the Surgeon General seems about to be erased.

John Gardner is quoted as having written that recruitment and development of talent is the first rule for the establishment of an effective organization, and that the personnel system is of prime importance in improving departmental administration.[11] This equally applies to the Department of HEW and the PHS. These principles appear to be in jeopardy in the present environment in Washington.

Two fundamental recommendations would appear appropriate. The first is that there be developed a long-range program through a true partnership of government and the private sector, that is, concerned with the role, status, recruitment, education, training, and retention of adequate numbers of career health administrators. HEW, through its division on health manpower, the universities through their schools of public health, hospital and business administration and the national health organizations, such as AAMC, AMA, AHA, APHA, ANA, ADA, NLN, and the like, should quite logically combine their talents and resources to measure needs, devise programs, and assure implementation through cooperation.

The second recommendation is of greater urgency. This is that there be resolution of the current uncertainty regarding the organization and leadership for health in HEW, and particularly the mission, status, responsibility, and future of the Public Health Service, its Commissioned Corps, and its Surgeon General before they disappear without effective replacement.

There is no question but that the PHS and its Surgeon General have had to function within the political arena, so that the top career health professionals —although professionally nonpartisan— can hardly be said to be nonpolitical. The selection of the Surgeon General has been political and, in some cases, partisan. The problem is how to provide political accountability in a democratic government, but at the same time provide professional responsibility in a field that should not brook partisan politics.

Public policy must be determined by the electorate, the consumer, or the public for whom services are rendered and who underwrite the cost. The expertise through which policy is developed and upon which implementation must depend should come from the informed career professional who is given authority commensurate with his responsibility, who is receptive to public needs and demands, but who can provide expertise and continuity. The federal government needs a staff that has knowledge, ability, and experience molded into an organization that has leadership, morale, and pride. The PHS, its Surgeon General, and its Commissioned Corps, which provided this in the past, has been seriously eroded. Either it needs to be reconstituted and strengthened or it needs to be replaced. Whatever is done, should be done promptly—or the work of those years which developed leaders of reputation, of experience, and of dedication will be largely destroyed. The construction of a replacement organization would be laborious and time-consuming.

The logical steps, if there is to be a continuity of professional leadership re-

gardless of the vagaries of partisan political appointments, would include: definition of the mission of the PHS or its successor organization of professionals; establishment of the numbers and types of career professionals that are required to reach this goal; and delineation of the leadership, the authority, and the staff required by the career professional leader.

This action should be taken promtply. Meaningful consultation with acknowledged leaders in health administration and with the voluntary national health organizations is obviously desirable. The Secretary of HEW and his new Assistant Secretary for Health and Scientific Affairs are in an ideal situation to take constructive steps that can bring order out of confusion. They need not be concerned over face-saving or over justifying actions or decisions that were taken by their predecessors. Much of what has happened may well have been logical or appropriate at that particular time—and nothing can be gained by recrimination or second guessing. The objectives and the motivations of the past were to meet problems of health that were complex and almost overwhelming. Similar objectives exist today. With past experience as a guide, a constructive and fresh approach is possible.

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